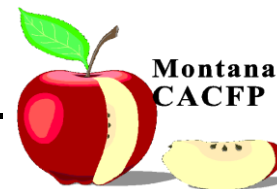


# Claim Form for Reimbursement

## CHILD AND ADULT CARE FOOD PROGRAM



Institution: \_\_\_\_\_

For the Month of \_\_\_\_\_ 20 \_\_\_\_\_

Provider #:

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For example:

1 2 3 4 5 A

Claims are **due on** or before the **10th** of each month. **Claims not received within 60 days of the claim month will not be paid** [REF: 7 CFR 226.10(e)] without USDA approval for a one-time exception.

<p>____ Licensed Capacity</p> <p>____ Number of Facilities</p> <p>____ Total Monthly Attendance</p> <p>____ Average Daily Attendance (total monthly attendance divided by number of days meals were served)</p> <p>____ Number of Days CACFP Meals Were Served</p>	<p>Current Month Enrollment:</p> <p>____ Free</p> <p>____ Reduced</p> <p>____ Paid</p> <p>____ Total Enrolled</p>
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Total CACFP Meals Served to Enrolled Children:

\_\_\_\_ Breakfast

\_\_\_\_ Lunch

\_\_\_\_ Supper

\_\_\_\_ Snack / Supplement

**For Profit (FR/P) Centers Only** (see reverse side for instruction)

**Proprietary FR/P Certification:** The institution certifies that at least 25% of enrolled children, or 25% of licensed capacity, **whichever is less**, are classified as Free or Reduced, and meet eligibility requirements for this reporting month.

# of F/R Children: \_\_\_\_ Total Enrollment: \_\_\_\_ Licensed Capacity: \_\_\_\_

\_\_\_\_\_  
Authorized Signature

I certify that to the best of my knowledge and belief, this claim is true and correct, records are available to support it, it is in accordance with an existing agreement and applicable licensing requirements, and payment has not been received. I understand that this information is being given in receipt of federal funds and that deliberate misrepresentation of the information may subject me to prosecution under applicable state or federal laws.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Phone \_\_\_\_\_

Child and Adult Care Food Program  
PO Box 202925  
Helena, MT 59620-2925  
Fax: 406-444-2547  
Toll Free: 888-307-9333

**Retain a copy for your files**

## CLAIM INSTRUCTIONS

### TOTAL MONTHLY ATTENDANCE

Record the total number of participants in attendance daily. This should include every participant who attended during the day.

Each month, add together the attendance totals from each day. This is the total monthly attendance.

### AVERAGE DAILY ATTENDANCE

*(Round this number up to the nearest whole number)*

$$\text{Average Daily Attendance} = \frac{\text{Total Monthly Attendance}}{\text{Number of Days the Center Operated}}$$

### FR/P CERTIFICATION

1. Add Free and Reduced participants;
2. Compare the enrollment and licensed capacity, selecting the lesser number; then,
3. Divide F/R Participants by the lesser of enrollment or licensed capacity to determine if your center has met the 25% minimum and are eligible to submit a claim. The answer should be .25 or more.

4. **Example #1:**

# Of F/R Children:	7	
Total Enrollment:	36	
Licensed Capacity:	30	← Capacity is less than Enrollment.

$$\begin{array}{r} .233 \\ 30 \overline{) 7.0} \\ \underline{- 60} \\ 100 \\ \underline{- 90} \\ 10 \end{array}$$

.233

23.3% is less than 25%;  
this center **may not** claim.

Move the decimal  
two places to the  
right to convert to a  
percentage.

5. **Example #2:**

# Of F/R Children:	12	
Total Enrollment:	46	
Licensed Capacity:	35	← Capacity is less than Enrollment.

$$\begin{array}{r} .342 \\ 35 \overline{) 12.0} \\ \underline{- 105} \\ 150 \\ \underline{- 140} \\ 100 \\ \underline{- 70} \end{array}$$

.342

34.2% is more than 25%;  
this center **may** claim.

Move the decimal  
two places to the  
right to convert to a  
percentage.

This claim form is available on the CACFP website at [www.bestbeginnings.mt.gov](http://www.bestbeginnings.mt.gov)